STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155789	B. WING		09/18/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		AMPUS DR		
RIDGEW	OOD HEALTH CA	MPUS		ENCEBURG, IN 47025		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This visit was for	or the Investigation of	F0000	The submission of this Plan of		
		_	10000	Correction does not indicate a		
	Complaint IN00	)11548/.		admission by RidgeWood Hea		
				Campus that the findings and		
		115487 Substantiated.		allegations contained herein a	re	
	Federal/State de	eficiencies related to the		accurate and true representat	ons	
	allegations are o	eited at F441 and F514.		of the quality of care and serv	ces	
				provided to the residents of		
	Survey dates: S	September 17 and 18, 2012		RidgeWood Health Campus.		
	Survey dates.	repression 17 una 10, 2012		This facility recognized it's		
	F:1141	012522		obligation to provide legally ar medically necessary care and	iu	
	Facility number: 012523			services to its residents in an		
	Provider number: 155789			economic and efficient manne	r.	
	AIM number: 2	201027870		The facility hereby maintains i		
				in substantial compliance with		
	Survey team: P	enny Marlatt, RN		requirements of participation f	or	
		•		comprehensive health care		
	Census bed type	·		facilities (for Title 18/19		
	SNF: 37			programs). To this end, this pl of correction shall serve as the		
	SNF/NF: 19			credible allegation of compliar		
				with all state and federal		
	Residential: 39			requirements governing the		
	Total: 95			management of this facility. It	is	
				thus submitted as a matter of		
	Census payor ty	rpe:		statue only.		
	Medicare: 30					
	Medicaid: 16					
	Other: 49					
	Total: 95					
	10.01. 75					
	Sample: 4					
		ies reflect State findings				
	cited in accorda	nce with 410 IAC 16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155789	A. BUILDING  B. WING	00	COMPLETED 09/18/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  181 CAMPUS DR  LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	Quality review com Cathy Emswiller R	pleted 9/24/12					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HTUS11

Facility ID: 012523

If continuation sheet Page 2 of 15

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155789	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED 09/18/2012			
		B. WING	ADDRESS CITY STATE 7ID CODE	1			
	PROVIDER OR SUPPLIER OOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  181 CAMPUS DR  LAWRENCEBURG, IN 47025					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as	TAU		DATE			
	isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash						
	their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  Based on interview, observation and record review, the facility failed to ensure	F0441	RN#1 and LPN#1 were reeducated by the DHS/design	10/15/2012			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HTUS11

Facility ID: 012523

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED	
		155789	B. WIN			09/18/2012	
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			181 CA	MPUS DR		
	OOD HEALTH CAN				ENCEBURG, IN 47025		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
	1 1 1	hygiene was utilized:			on proper hand washing technique with an emphasis or	n	
		sing change observations			dressing changes and medical		
		aff in 1 of 3 residents			adminstration before 10/15/12		
	reviewed for dre	ssing changes in a sample					
	of 4. (Resident #	#C, RN #1, LPN #1)			2. All licensed staff were		
	B. in 2 of 2 obse	ervations of blood			re-educated on proper hand		
	glucose and/or in	nsulin administration in 2			washing technique with an emphasis on dressing change:		
	of 3 residents rev	viewed for blood glucose			and medication adminstration		
		nistration in a sample of			DHS/designee before 10/15/12	-	
		Resident #D, RN #1)					
		, , , ,			3. The DHS/designee will		
	Findings include				complete hand washing audits of licensed staff during dressing	of	
	i mamgs merade	igo merade.			changes and medication		
	A Posidont #C'	s clinical record was			administration to assure		
					compliance.		
		8-12 at 9:31 a.m. Her			4. These Audits will be		
	_	ed, but were not limited			conducted on 10% of licensed		
		hronic leg wounds.			staff weekly x 3months, once 100% compliance is obtained		
	1 -	on 8-30-12 indicated to			audits will decrease to quarter	V.	
	_	previous treatment to the			Licensed staff will be reeducat	- 1	
		egin daily dressings			and counseled as required. All		
		sing the left shin wounds			audits will be reviewed during		
	with normal sali	ne, apply Santyl and			daily CCM meeting, and month	-	
	cover with a dry	dressing.			during quality assurance meet	ing.	
	In observation of	f the dressing change on					
		o.m. with RN #1, after the					
		yed to remove the					
	_	liscard the items in a bag					
	_	hands. She then removed					
		iscarded them into the					
	_	onned a new set of gloves					
		giene being performed.					
	She then continu	ed with the dressing					
	change by cleans	sing the left shin wounds					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HTUS11

Facility ID: 012523

If continuation sheet Page 4 of 15

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE S COMPLE		
AND PLAN	OF CORRECTION	155789	A. BUILDING	00	09/18/2	
		155769	B. WING			2012
NAME OF F	PROVIDER OR SUPPLIER			AAABUR DB	3	
DIDGEW	OOD HEALTH CAN	MDI IQ		AMPUS DR ENCEBURG, IN 47025		
				LINCEBONG, IN 47025		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	TION	(X5)
PREFIX TAG	1	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
TAG		ne and dried the areas	TAG			DATE
	_	then discarded the items				
		gloved hands and				
	_	ves prior to performing				
	hand hygiene.					
		rvation of Resident #C's				
		on 9-18-12 at 3:15 p.m.				
	· · · · · · · · · · · · · · · · · · ·	e nurse was observed to				
		sing and then to discard				
		oag. Without changing				
	_	observed to open the				
		s and to cleanse the left				
	shin wounds wit	h normal saline and to				
	dry the area with	gauze. She then				
	removed the glo	ves and performed hand				
	hygiene.					
	D.1 Duning on	observation with DN #1				
		observation with RN #1				
		22 p.m. with Resident				
		is observed to disinfect				
		fter obtaining the				
		glucose. Hand hygiene				
		d to be performed after				
		glucometer, nor prior to				
		After donning the				
	"	nen drew up Resident #C's				
	insulin dosage.					
	R 2 During an	observation with RN #1				
	I -	44 p.m. with Resident				
		•				
		as observed to administer				
		to the resident at 4:49				
	p.m., followed b	y performance of hand				

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Event ID: HTUS11

Facility ID: 012523

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE : COMPL		
ANDILLAN	OI CORRECTION	155789		LDING	00	09/18/	
		100700	B. WIN		PPPPG GWW GW == ===	03/10/	_ · · · ·
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  MPUS DR		
RIDGEW	OOD HEALTH CAN	MPUS			NCEBURG, IN 47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		rse was then called to					
	_	none at the nurse's station					
		g to the medication cart.					
		erved to perform hand					
		swering the telephone and					
		g medication for the next					
	resident.						
		D37.114 0.45.15					
		n RN #1 on 9-17-12 at					
		to providing care to					
		e indicated, "We normally					
		zer on the [medication]					
		normally wash my hands					
		s. I guess I just forgot."					
		n RN #1 on 9-17-12 at					
		dicated, "I should have					
		hygiene after I got off the					
	phone."						
	A policy entitled	, "General Guidelines for					
	Dressing Change	es," with a effective date					
	of December 200	99 was provided by the					
	Administrator or	19-18-12 at 3:37 p.m.					
	This policy indic	eated, "Wash hands					
		ater. Put on first pair of					
	disposable glove	s. Remove soiled					
		card in plastic bag.					
	_	es in plastic bag. Wash					
		and water. Put on					
	-	sposable gloves. Follow					
	•	endations for treatment.					
		and secure with tape when					
		entRemove gloves and					
		inused supplies in plastic					
		** *					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HTUS11

Facility ID: 012523

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155789		(X2) MULTIPLE CO	00	COMPLETED 09/18/2012
	1997.09	B. WING		09/10/2012
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE  MPUS DR	
RIDGEW	OOD HEALTH CAMPUS		NCEBURG, IN 47025	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	bag. Wash hands with soap and water"			
	A policy entitled, "Specific Medication Administration Procedures," with an effective date of 2-1-2010 was provided by the Director of Nursing on 9-18-12 at 12:57 p.m. This policy indicated, "Cleanse hands using antimicrobial soap and water or facility-approved hand sanitizer before beginning med pass, before handling medication, and before contact with the residentWhen finished with each resident, wash hands with antimicrobial soap and water or use facility-approved hand sanitizer."			
	A policy entitled, "Guidelines for Handwashing," with an effective date of October 2004, was provided by the Director of Nursing on 9-18-12 at 9:07 a.m. This policy indicated, "Handwashing is the single most important factor in preventing transmission of infectionsHealth Care Workers shall wash hands at times such as:Before/after having direct physical contact with residents. After removing gloves, worn per Standard Precautions for direct care with excretions or secretionsresident equipmentWaterless hand cleaning products such as alcohol based gels, foams, rinses provide an acceptable alternative to handwashing in certain			

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Event ID: HTUS11

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If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIF DEF CORRECTION IDENTIFICATION NUMBER 155789	BER:	2) MULTIPLE COI BUILDING WING	00	COMPL 09/18/	ETED	
	ROVIDER OR SUPPLIER  OOD HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE  181 CAMPUS DR  LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENT (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	circumstances"						
	This federal tag relates to complain IN00115487.	ıt					
	3.1-18(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HTUS11

Facility ID: 012523

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	A. BUILDING 00			COMPLETED	
		155789	B. WIN		<del></del>	09/18/2	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				MPUS DR			
DIDGEW	OOD HEALTH CAN	ADI IS			ENCEBURG, IN 47025			
KIDGEW	OOD HEALTH CAN	MF 03		LAVVINL	ENCEBORG, IN 47025			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0514	483.75(I)(1)							
SS=D	RES							
		PLETE/ACCURATE/ACCE						
	SSIBLE							
	-	maintain clinical records on						
		accordance with accepted dards and practices that						
		curately documented;						
		e; and systematically						
	organized.	, and systematically						
	The clinical recor	d must contain sufficient						
	information to ide	ntify the resident; a record						
	of the resident's a	ssessments; the plan of						
	care and services	provided; the results of						
		screening conducted by						
	the State; and pro	_						
	Based on intervi	ew and record review, the	F05	14	DHS/designee notified	i	10/15/2012	
	facility failed to	ensure accurate			residents #A, #C, and #D			
	documentation o	f care and services			physcian to assure accuracy o	ıt		
	provided for 3 of	f 3 residents reviewed for			insulin orders on 9-18-12.  2. All other residents with	_		
	*	sample of 4 was			insulin orders were reviewed b			
		dents #A, #C and #D)			the DHS/designee to assure n	•		
	provided. (Resid	ients #A, #C and #D)			other residents were effected.			
					Any deficient practice was			
	Findings include	:			corrected.			
					<ol><li>Licensed Staff have be</li></ol>	een		
	1. Resident #A's	clinical record was			in-serviced by DHS/designee			
		7-12 at 2:35 p.m. His			related to ensuring that Insulin			
		ed, but were not limited			Orders are accurately			
					documented.			
		opathy, osteomylitis			4. DHS/ designee will rev			
	,	and cellulitis (skin			new Insulin orders and mars d for one month, and then weekl	-		
	infection.)				for one month or until substant	-		
					compliance is achieved. Nurs			
	Physician orders	indicated he was to have			will be educated and counsele			
	-	blood sugar (BG) testing			as necessary for noncomplian			
	_	e each meal and at			Ongoing monitoring will take			
	•				place as part of daily CCM			
	beatime, with a s	sliding scale dose of			meetings and monthly QA.			

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Event ID: HTUS11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	î î	TE SURVEY  IPLETED	
ANDILAN	OF CORRECTION	155789	A. BUILDING	00		18/2012
		100700	B. WING	NEW ADDRESS OVER SEASON OF THE		10/2012
NAME OF F	PROVIDER OR SUPPLIER	1		EET ADDRESS, CITY, STATE, ZIP CAMPUS DR	CODE	
RIDGEW	OOD HEALTH CAN	MPUS		VRENCEBURG, IN 47025		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	20 20	DATE
	insulin to be given before each meal and			Quality Assurance Corequire Corrective Ac		
		d on the BG results. The		any pattern of non-co		
	_	alin orders indicated to			•	
	_	f the BG was under 141.				
		, to administer 4 units of				
		1 to 250, administer 8				
		from 251 to 300,				
		its of insulin; from 301				
	·	er 16 units of insulin;				
		, administer 20 units of				
		400, the facility was to				
	contact the physi	ician for instructions for				
	care.					
		ledication Administration				
	` ′	ndicated on 8-18-12 at				
		was 168; it indicated no				
		inistered. On 8-19-12 at				
		G was 387 and indicated				
		in were administered; at				
	dinner time, the					
		ılin was administered; at				
	· ·	was 305 and 4 units of				
		ninistered. On 8-26-12, at				
	l '	G was 438 and indicated				
		dministered; at bedtime				
	the BG was 191	and indicated no insulin				
l	was administered	d.				
l	Review of the M	IAR for August 2012				
		of documentation for BG				
		nsulin administration for				
	•	2 and 8-23-12 for supper				
	and bedtime. Th	ne facility was unable to				

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Event ID: HTUS11

Facility ID: 012523

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155789		(X2) MULTII  A. BUILDING  B. WING		00	(X3) DATE S COMPL 09/18/	ETED	
	PROVIDER OR SUPPLIER		ST 18	1 CAN	DDRESS, CITY, STATE, ZIP CODE IPUS DR NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	provide a copy of 2012 prior to the indicate the BG and interview with 2:37 p.m., she in excuse whatsoev of Resident #A]' insulin. I can tell blood sugar each sharp. I don't rechave no excuse for the excuse whatsoev of Resident #C's reviewed on 9-13 diagnoses include to diabetes and compared to diabetes and compared to the excuse of the excuse for the excuse for the excuse for the excuse of the excuse for the excuse of	f the MAR for September end of the survey to and insulin information.  LPN #1 on 9-18-12 at dicated, "I have no rer for not charting [name is blood sugars and l you he expected his evening at 4pm and 9pm call not doing them, but I for not charting them."  Colinical record was 8-12 at 9:31 a.m. Her red, but were not limited thronic leg wounds.  indicated she was to performed before each ime, with a sliding scale to be given before each ime, based on the BG ing scale insulin orders in o insulin if the BG was in 141 to 200, to			CROSS-REFERENCED TO THE APPROPRIA	ATE	
	250, administer 2 251 to 300, administration 301 to 350, insulin; from 35 units of insulin;	t of insulin; from 201 to 2 units of insulin; from inister 3 units of insulin; administer 4 units of 1 to 400, administer 5 for over 400, administer in and the facility was to ician for further					

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Event ID: HTUS11

Facility ID: 012523

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155789	B. WIN			09/18/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DIDOEW		40.10			MPUS DR		
RIDGEWOOD HEALTH CAMPUS				LAWRE	NCEBURG, IN 47025		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION	
TAG	, , , , , , , , , , , , , , , , , , ,		+	TAG	DEFICIENCI)		DATE
	instructions for c	eare.					
		ugust 2012 MAR					
		-12, the supper BG was					
		in was administered; on					
		ch BG was 150 and no					
		inistered; on 8-12-12, the					
	lunch BG was 21	15 and no insulin was					
	given.						
	Review of the September 2012 MAR						
	indicated on the	supper BG on 9-14-12					
	and 9-15-12 was	143 and no insulin was					
	administered.						
	Review of the M	AR for August 2012					
		of documentation for BG					
		in administration for					
	_	12; for breakfast, lunch,					
		me on 8-8-12; for supper					
		8-9-12; for supper and					
		-12, 8-14-12 and 8-15-12;					
	•	nch, supper and bedtime					
	· · · · · · · · · · · · · · · · · · ·	oreakfast and lunch on					
	· ·	akfast on 8-20-12; for					
		me on 8-21-12, 8-22-12					
	and 8-23-12; for	supper and bedtime on					
	8-28-12; for brea	akfast, supper and					
	bedtime on 8-29	-12 and for lunch on					
	8-30-12.						
	Review of the M	AR for September 2012					
		of documentation for BG					
		in administration for					
	Joseph and moun						

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
155789			B. WING			09/18/2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
			181 CAMPUS DR				
RIDGEWOOD HEALTH CAMPUS				LAWRE	NCEBURG, IN 47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E COMPLETION	
PREFIX TAG							
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	BEI ICIENCI)	DATE	
	supper 9-3-12; for supper and bedtime for 9-10-12, 9-11-12 and 9-12-12; for						
		nch 9-14-12 and for					
	supper and bedtime on 9-16-12.						
	3 The clinical r	ecord of Resident #D was					
		8-12 at 10:15 a.m. His					
	_	ed, but were not limited					
		entia, neuropathy and					
	gouty arthritis.						
	Physician orders	indicated he was to have					
	Physician orders indicated he was to have BG testing performed before each meal						
	· ·						
		with a sliding scale dose					
	·	given before each meal					
		pased on the BG results.					
	_	insulin orders indicated					
	•	n if the BG was under					
		o 200, to administer 2					
	units of insulin;						
		ts of insulin; from 251 to					
	· ·	6 units of insulin; from					
	· ·	inister 8 units of insulin;					
	· · · · · · · · · · · · · · · · · · ·	administer 10 units of					
		400, administer 16 units					
		e facility was to contact					
	the physician for	further instructions for					
	care.						
	D. 1. 64 A	/ 2012 MAD					
		ugust 2012 MAR					
		-12, the bedtime BG was					
		in was administered; on					
	8-9-12, the breakfast BG was 145 and no						
	insulin was admi	inistered; on 8-10-12, the					

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l ' '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
		IDENTIFICATION NUMBER:	A. BUI	ILDING 00		COMPLETED	
155789			B. WIN			09/18/	2012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
DIDOEM	1000 HEALTH 0AA	45110	181 CAMPUS DR				
RIDGEWOOD HEALTH CAMPUS				LAWRE	NCEBURG, IN 47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  lunch BG was 149 and 1 unit of insulin			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
TAG				TAG	BEIGHACT		DATE
		d; on 8-19-12, the					
		249 and 6 units of					
	insulin was administered; on 8-22-12, the lunch BG was 201 and 2 units of insulin						
		d. Review of the					
	_	MAR did not indicate					
	any incorrect do	· ·					
	administered bas	sed on BG results.					
	Review of the MAR for August 2012						
	indicated a lack of documentation for BG						
	testing and insulin administration for						
	breakfast and lunch on 8-2-12, 8-4-12 and						
	8-6-12; for lunch on 8-7-12; for breakfast,						
	lunch, supper and bedtime on 8-8-12; for						
	bedtime on 8-9-1	12; for supper and					
	bedtime on 8-13	-12, 8-14-12, 8-15-12 and					
	8-16-12; for brea	akfast and lunch on					
	8-17-12; for sup	per and bedtime on					
	8-21-12, 8-22-12	2, 8-23-12, 8-27-12 and					
	8-28-12.						
	Review of the MAR for September 2012						
		of documentation for BG					
		in administration for					
	~	2; for supper and bedtime					
		-12, 9-12-12 and					
	9-16-12.	-12, 7-12-12 allu					
	)-10-12.						
	A policy entitled	l, "Specific Medication					
	Administration I	Procedures," with an					
	effective date of 2-1-2010 was provided						
	by the Director of	of Nursing on 9-18-12 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155789		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/18/2012			
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  181 CAMPUS DR  LAWRENCEBURG, IN 47025					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	"Policy: To adm safe and effective for [physician's in medication label to removing the package/contained 2) prior to remove the package/contained cart/drawer. Con MARObtain an or other monitor deemed necessare administration. Teturn to cart, reproduced the package of the	er from the cart/drawer; ving the medication from tainer; 3) as the er is returned to the mpare label to and record any vital signs ing parameters ordered or by prior to medication After administration,						

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